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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

ANA MARIA PAINTER
Petitioner,

VS.

GOLDEN RULE INSURANCE COMAPNY.
Respondent.

Petition for a Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Are disputes between a health insurer who has not served as an ERISA primary party and the policyholder which arise under individual policies of conversion issued after the termination of COBRA coverage, preempted by ERISA? Does it make any difference whether the employer and the benefit plan had already terminated any relationship with that insurer and thereby terminated COBRA coverage?

2. Does ERISA preempt state regulation of conduct of a health insurer who is not an ERISA primary party, with respect to the insurer's instituting and continuing litigation in controvention of ERISA §502(a)(1)'s limitation of suits to determine participants' rights to participants and beneficiaries? Is a state suit attacking such litigation conduct by the health insurer removable to the federal district court?

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PETITION FOR WRIT OF CERTIORARI

Petitioner, plaintiff and appellant below, prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, which affirmed the decision of the district court, on August 14, 1997, so that this Court might

> (1) resolve or reduce the confusion that continues to exist unabated in actions brought by individuals, with respect to the words "relates to" in the supercession provision of §514 of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1144(a), as covering misconduct committed *outside of* and following conclusion of benefit plan administration, and in which entitlement to plan benefits would be irrelevant, and
>
> (2) resolve or reduce the confusion that exists with respect to whether health coverages provided in health insurance conversion policies that exist between the former employee and the state-regulated commercial health insurer, and under which the obligations referred to in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9, 11 (1987), are disclaimed or nonexistent, constitute ERISA benefit plans because the terms of the prior plan or Congressional mandate made some reference to or compelled the issuance of that conversion policy.

There is compelling reason for review: first, the importance of health insurance coverage concerns, the more so as a result of the Health Insurance Portability and Accountability Act (Pub. L. 104-141), which in part amends ERISA, "locking" even more of the disadvantaged community into ERISA preemption long after any employment relationship terminated; second, a present lack of uniformity amongst the circuits and the district courts in determining in which forum, federal or state, and under what

laws is the conduct of those insurers not serving as plan administrators, plan fiduciaries or any other of the ERISA "quartet," to be judged, defeating the strong Congressional desire for national uniformity *if* conversion policies truly constitute preempted ERISA plans; and third, if individual conversion policies are determined to be ERISA benefit plans, such will allow the Secretary to engage in further rule-making and regulation, for until now there appears to be no attempt by the Secretary to so require registration of such "plans" under ERISA §103 and §104, 29 U.S.C. §§1023, 1024, or issue regulations pertaining thereto.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, rendered August 14, 1997, is reported at 121 F.3d 436, and is reprinted in the appendix hereto as A-1 to A-10. A petition for rehearing or rehearing en banc was denied November 17, 1997, and appears in the appendix as A-11. The opinion of the United States District Court for the Eastern District of Missouri is not published, but is reprinted in the appendix as A-12 to A-16.

JURISDICTIONAL STATEMENT

Petitioner instituted this action in the state court alleging the state tort of prior abuse of legal process by the respondent who was never a member of the ERISA "quartet;" petitioner claimed neither benefit under an ERISA benefits plan or under an insurance policy, nor wrongful benefit denial in her suit. Respondent removed this action to federal court. The district court asserted that it had jurisdiction of this action pursuant to 28 U.S.C. §1331 and 29 U.S.C. §1001 *et seq*; found petitioner had pleaded no valid ERISA cause of action and granted summary judgment in favor of respondent; and entered a final judgment with prejudice against petitioner.

An appeal was taken to the Eight Circuit Court of Appeals pursuant to 28 U.S.C. §1291. The judgment of the Court of Appeals was entered August 14, 1997. Petitioner filed a petition for rehearing by the panel, or, alternatively, for rehearing en banc. The Court of Appeals denied the petition November 17, 1997.

The Department of Labor sought leave to file a memorandum in favor of rehearing, opposing the extension of ERISA preemption to relations between insured and insurer under individual conversion health insurance policies. The Court of Appeals rejected the memorandum as out of time on December 17, 1997 and never considered the substance of the government's argument.

Pursuant to Supreme Court Rule 13.1, this petition has been filed within 90 days of the denial of rehearing. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254(1).

STATUTES INVOLVED

ERISA (29 U.S.C.), as amended by COBRA and HIPAA, provides:

§**1002**. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan;

(16)(A) The term "administrator" means--

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor;

§**1144**. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

(b) Construction and application

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

§**1162**. Continuation coverage

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) Maximum required period

(i) General rule for terminations and reduced hours

In the case of a qualifying event described in section 1163(2) of this title, except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(B) End of plan

The date on which the employer ceases to provide any group health plan to any employee.

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

§1181. Increased portability through limitation on preexisting condition exclusions

(e) Certifications and Disclosure of Coverage.--

(1) Requirement for certification of period of credible coverage.--

(A) In general.--

A group health plan shall provide the certification de scribed in subparagraph (B)--

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(B) Certification.--

The certification described in this subparagraph is a written certification of--

(i) the period of creditable coverage of the individual under such plan and the coverage under such COBRA continuation provision, and

STATEMENT OF THE CASE

Petitioner worked for M.D. Care, Inc., which provided her and her co-employees with group health benefits through the purchase of a health insurance policy from respondent Golden Rule Insurance Company. She required treatment for ovarian cancer, and her employment was terminated at the end of August 1992. She was offered and elected coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). During this period of COBRA coverage petitioner moved to Missouri where the health insurer, respondent, refused to preauthorize high dose chemotherapy recommended by petitioner's various oncologists. Petitioner claimed that refusal was in conflict with the terms of the COBRA coverage. After only five months of COBRA coverage, on February 1, 1993 M.D. Care, Inc. canceled the group policy and ceased any relationship with respondent insurer. Its plan, if it continued, no longer provided health benefits through any policy issued by respondent. Petitioner did not hear from the employer again. No one then offered to continue petitioner's COBRA coverage which had another 13 months to run.

Later, in April 1993, respondent insurer offered to provide petitioner an individual policy which respondent designated a conversion policy, but at much higher rates and with far different terms than in the prior group policy, to be made retroactive to February 1. The delay in making such offer has never been

explained. Having no other alternative because of her medical condition, petitioner accepted.

Notwithstanding lack of preauthorization, petitioner as then Medicaid qualified, was finally able to obtain the high dose chemotherapy treatment, and later presented her medical bills to respondent for payment. Respondent refused to pay under the terms of the conversion policy. After its final denial and contrary to the terms it imposed in its policy preventing suit, respondent filed suit against petitioner in the Eastern District of Missouri, alleging that it was a "participant." ("Painter I"). At no time did respondent claim to be either employer, plan sponsor, plan administrator, plan fiduciary or an ERISA "primary party." But it did allege jurisdiction under ERISA, sought declaratory relief provided under ERISA §502(a)(1), 29 U.S.C. §1132(a)(1) only to participants and beneficiaries, and also sought an order that petitioner pay its costs and fees even though it knew petitioner was virtually penniless. Petitioner's dismissal motions were ignored; she was obliged to prepare for trial.

During the course of proceedings in Painter I, respondent (as plaintiff) advised the court that not only in its view did petitioner have claims under ERISA for its denial of coverage, but also under the Americans with Disabilities Act and Title VII of the Civil Rights Act, and that the Equal Employment Opportunity Commission had not yet issued right-to-sue letters. What the Court of Appeals said was three years after respondent instituted that prior suit, the district court permitted respondent to voluntarily dismiss without prejudice under Fed. R. Civ. P. 42(a)(2).

Petitioner then filed the instant suit ("Painter II") in the state court solely against respondent for abuse of process under state law. Missouri recognizes that civil actions may be abusive or brought for abusive purposes, and makes such a tort. In her state court suit petitioner did not claim entitlement to any plan benefit, or that such benefit had been wrongfully denied. Only

respondent's litigation conduct as insurer was challenged. There was no challenge to any *prior* internal claims administration, which had come to an end before respondent had earlier filed its suit, which was not authorized by ERISA. Petitioner sued no ERISA primary party.

Respondent removed the suit to the Eastern District of Missouri. The district court rejected petitioner's motion to remand, found that the suit petitioner filed dealt with ERISA benefits under the conversion policy, ignored any possible ADA and CRA claims that ERISA does not preempt, and found the suit wholly ERISA-preempted because the conversion policy from which the district court viewed petitioner's claim to have emanated, constituted an ERISA welfare benefits plan. The district court offered petitioner no opportunity to amend, and dismissed her suit with prejudice. App-12 to App-16.

The United States Court of Appeals for the Eighth Circuit affirmed. App-1 to App-10. It opined that respondent's ERISA-prohibited litigation conduct after administrative denial was only a "mishandling of that claim" and held that even if the underlying group policy expired and the employer and plan ended their use of respondent to fund plan benefits, all policies having their origins emanating from ERISA plans are components of the ERISA plans themselves.

REASONS FOR GRANTING THE WRIT

In actions in which individual interests rather than institutional interests are involved, the lower courts are still not heeding this Court's admonition that the term "relates to" is being applied far beyond allowable limits. Performance by the insurer under individual health insurance policies solely between the insurer and individual policyholder, "emanating from" prior coverage under ERISA group policies under COBRA or HIPAA

amendments to ERISA, does not "relate to" obligations or administration of a prior ERISA benefit plan that no longer exists for the group or the individual. Although ERISA was enacted to create a "national uniformity," the courts cannot agree whether ERISA controls individual conversion policies.

ERISA is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). ERISA's general preemption clause, §514(a), preempts "any and all state laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. §1144(a). This Court in three recent decisions has focused attention on the traditional presumption that Congress does not intend to preempt traditional areas of state regulation without a clear and manifest statement of such purpose.

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for "[r]eally, universally, relations stop nowhere. . . ." But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 655 (1995) (citation omitted). Frankly observing that "our prior attempt to construe the phrase 'relate to' does not give us much help in drawing the line[,]" the unanimous *Travelers* Court held that courts must "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 655-56. *See also DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747, 1751, 138 L.Ed.2d 21 (1997) (reiterating *Travelers* holding that the starting presump-

tion in ERISA preemption analysis is that Congress does not intend to supplant state law).

It must be kept in mind that even without the continuation obligations compelled by COBRA and by the Health Insurance Portability and Accountability Act ("HIPAA"), state law usually requires insurers to offer conversion rights. Courts have held that state statutes mandating that insurers offer conversion rights to plan participants whose employers have purchased group policies *not* preempted. *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991), *cert. denied*, 504 U.S. 973 (1992); *United of Omaha v. Business Men's Assurance Co. of America*, 104 F.3d 1034 (8th Cir. 1997) (Missouri law requiring health conversion coverage not preempted); *Henkin v. Northrup Corp.*, 921 F.2d 864, 867 (9th Cir. 1990). The reasoning of these cases is based on *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), where the Court held that a Massachusetts statute of universal application to the insurance industry mandating certain mental health benefits was not preempted inasmuch as it was a form of insurance regulation "saved" under ERISA § 514(b)(2)(A).

But at the same time the right to convert to an individual insurance policy is also a benefit offered by many health, life, and other group plans. As with other benefits such plans might offer, this right to convert is governed by ERISA. Indeed, as it applies to participants under COBRA, plan terms governing the exercise of that right are specifically dealt with by the COBRA statute which provides that if a conversion right is offered to participants in general, it also must be offered on the same terms to COBRA participants. 29 U.S.C. §1162(5).

When it comes to individual health insurance policies "emanating from" a prior ERISA plan, there are many different views as to whether such further coverage is subject to ERISA preemption. The differences were recently noted in *Powers v. United*

Health Plans of New England, Inc., 979 F.Supp. 64 (D. Mass. 1997). See also *Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341 (11th Cir. 1994).

One view, adopted by the Court of Appeals in the instant case, is that there is ERISA preemption if health benefits provided under the prior ERISA relationship makes a path for later individual coverage with an insurer, whether a plan still exists or not. *See, e.g., Qualls v. Blue Cross of California*, 22 F.3d 839, 843 n.4 (9th Cir. 1994) ("[i]f the policy was governed by ERISA when he was [employed by] Saddleback, it continued to be governed by ERISA once he left");[1] *Beal v. Jefferson-Pilot Ins. Co.*, 798 F.Supp. 673, 675 (S.D. Ala. 1992) (the conversion policy "is an 'employee benefit plan' under ERISA"); *Mays v. UNUM Life Ins. Co. of America*, 1995 Westlaw 317102 (N.D. Ill. 1995) (individual conversion policy is an "extension of an ERISA plan"). *Cf. Glass v. United of Omaha Life Ins. Co., supra*, 33 F.3d at 1346-47 (if conversion is to a "group policy" it is preempted, but court expressly notes that it offers no opinion as to conversion to individual policy). The Sixth Circuit opts for this result if the continuation terms are the same as in the original plan coverage, *Reynolds v. Mass. Cas. Ins. Co.*, 113 F.3d 1450, 1453 (6th Cir. 1997), which did not occur in the instant case. Although there have been no cases yet, since HIPAA rights also emanate from prior participation in an ERISA plan, these courts

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[1]Although the issue in *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812 (9th Cir. 1992) did not involve a dispute as to the actual terms of the conversion policy, which were unquestionably complied with, but only as to what the terms should have been, the language of the Ninth Circuit is sufficiently broad to allow one to argue the dicta is that conversion policies are part and parcel of continuing ERISA plans. *Id.* at 817. See also *Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404, 407-08 (9th Cir.), *cert. denied*, 116 S. Ct. 377 (1995).

would likely include ERISA preemption of any continued coverage obtained as a result of the HIPAA provisions in ERISA.[2]

Another line of cases deal only with whether the right to convert, and what are to be the terms of conversion, are subject to ERISA. In these cases the courts do not venture further to discuss what law controls when a dispute later arises under the terms of a conversion policy. *See, e.g., Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124 (9th Cir. 1992) (issue solely as to right to convert, not performance under converted policy). Some that do have to venture further find no preemption once the conversion has occurred. *Mimbs v. Commercial Life Ins. Co.*, 818 F.Supp 1556 (S.D. Ga. 1993)

Another line of authority holds that there is no ERISA preemption for conversions to individual policies, once the conversion has properly taken place. *E.g., Powers v. United Health Plans of New England, Inc., supra*, 979 F.Supp. at 69 (if employer has no ongoing responsibility for the administration of the policy, there is no ERISA plan and no ERISA preemption)[3]; *Mimbs v. Commercial Life Ins. Co., supra*, 881 F.Supp. at 235-36 ("claims arising under the post-COBRA conversion policy itself, and not from the COBRA right to the conversion policy, are not preempted by ERISA and are governed by state law"); *McDonald v. Professional Insurance Corp.*, 946 F.Supp. 943, 945 (M.D. Ala. 1996); *McCale v. Union Labor Life Ins. Co.*, 881

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[2]Although not a HIPAA case, *Reynolds v. Mass. Cas. Ins. Co., supra*, dealt with a continuation policy which related to the underlying plan. It was not a conversion policy.

[3]More recently, in what is "Painter III" (*Ana Maria Painter v. Golden Rule Ins. Co. et al*, No. 4:96CV1917-ERW (E.D. Mo. memorandum decision, unpublished, October 14, 1997), the district court sua sponte declared the employer had no ongoing responsibility, and the plan could not be liable for paying plan benefits to plaintiff once M.D. Care, Inc. terminated the Golden Rule insurance and its relationship with respondent.

F.Supp. 233, 235-36 (S.D. W.Va. 1995); *Vaughn v. Owen Steel Co.*, 871 F.Supp. 247, 248-49 (D. S.C. 1994).

Compelling reasons exist to address this question, especially now that HIPAA is also included in ERISA. Health coverage issues so directly affect one's life, and are a matter of national concern. ERISA preemption creates devastating results when one is deprived of health care benefits promised in the policy. Even the courts view ERISA as unfair or inadequate and can lead to devastating results that are beyond the reach of equity to correct and outside the court's power to do anything about. *See, e.g., Andrews-Clark v. Travelers Ins. Co.*, 1997 Westlaw 677932, 1997 U.S. Dist. LEXIS 17390 (D. Mass. Oct. 30, 1997) (court has no authority to create a remedy for misconduct of medical benefit plan administrators whose wrongful plan denial of plan benefit leads to otherwise likely avoidable death of plan participant, no equity power to resurrect); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (although ERISA remedy structure is deficient in medical benefit denial cases, only Congress may correct); *Durham v. Health Net*, 108 F.3d 337 (table), 1997 Westlaw 66558 (9th Cir.), *cert. denied*, 118 S.Ct. 51 (1997) (where benefit plan delayed approval of a medically necessary treatment until it was too late to be used to help because of deterioration of patient's health during the wrongful-delay period, saving the plan money, no remedy for unjust enrichment for monies plan saved). Yet in spite of this, as the instant case illustrates, when it comes to individuals, even without an employer or plan sponsor or an ongoing benefit plan providing benefits and benefit administration, too many courts still favor the finding of ERISA preemption that insulates insurer breaches of a conversion policy from any meaningful remedy. In conversion cases, as the instant case, there is no longer even a plan fiduciary to remove, not that such relief would help a dead patient/policyholder.

Below the Secretary attempted to argue that "the act of converting from group to individual coverage severs the required nexus between the plan sponsor and the insured." The court in *Mimbs v. Commercial Life Ins. Co.*, *supra*, 881 F.Supp. at 1561-62 advised:

> There is no showing that the conversion coverage in this case contains the requisite elements of an ERISA plan. Furthermore, once conversion has occurred and the policy is in force, there is no longer any "integral connection" between the individual conversion policy and the ERISA plan that gave rise to the right to convert.

Likewise, there is no suggestion of any such "integral connection" in the instant case; in fact, the record shows the contrary. Whatever connection the district court or the Eighth Circuit had in mind in the instant case is a legal fiction. The Department of Labor argued that

> Once the conversion right is exercised and the conversion policy is in the participant's hands, the plan benefit (*i.e.*, the right to convert) has, in effect, been "paid," and the ERISA statute does not follow the conversion policy any more than it follows cash in the hands of a participant once cash has been paid out by a pension plan. *See*, *e.g.*, *Guidry v. Sheet Metal Workers National Pension Fund*, 39 F.3d 1078, 1082, 1086 (10th Cir. 1994) (en banc) (holding state garnishment laws not preempted with respect to money that has been paid out to participant by pension plan), *cert. denied*, 514 U.S. 1063 (1995). An even better analogy is the status of annuity contracts issued upon the termination of a pension plan. Even though the insurers who issue such annuities have an administrative scheme for paying the annuitants what they are owed, it is well established that state law governs these annuities once the annuities are in the hands of the participants. 29 C.F.R. §2510.3-3(d)(2)(ii);

see *Waller v. Blue Cross*, 32 F.3d 1337 (9th Cir. 1994). [footnote omitted]

In addition, the Secretary's regulation at 29 C.F.R. §2510.3-1(j) provides that group insurance arrangements, are *not* ERISA-covered plans where (1) there are no employer contributions, (2) participation is voluntary, (3) the role of employer is no more than to facilitate voluntary payment of premiums by participants, and (4) the employer receives no consideration. Individual conversion policies satisfy each of these criteria. While this regulation was admittedly designed for a purpose unrelated to conversion policies (*i.e.*, to provide a safe harbor to employers who facilitate their employees' voluntary purchase of insurance), we think the four part test set forth in the regulation is instructive.

Apart from the Secretary's regulations, this Court in *Fort Halifax Packing Co. v. Coyne*, *supra*, 482 U.S. at 9, 11, noted the necessity of the employer and the continuing obligations ERISA would impose on the employer were there a benefit plan to assure preemption of state law.

The Department of Labor also took issue that several of the cases cited by the Eighth Circuit for support did not actually involve claims under an individual conversion policy.[4] And then

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[4] *Howard v. Gleason Corp.*, 901 F.2d 1154 (2nd Cir. 1990), did not involve rights under a conversion policy, but the dispute was about the exercise of the right to convert. In *Klosterman v. Western General Management, Inc.*, 805 F.Supp. 570 (N.D. Ill. 1992), the issue likewise had to do with a right to convert, no policy ever having been issued. In *Beal v. Jefferson-Pilot Inc. Co.*, *supra*, the issue was whether there was "fraud in the inducement" to cause Mr. Beal to exercise his conversion right, not to claims made under a conversion policy after it had been issued.

the Department of Labor added policy considerations that petitioner as well alluded to in oral argument:

> The Secretary's view is buttressed by important practical and policy considerations as well. Implicit in [the Eighth Circuit's] holding is that a multitude of conversion policies currently in the hands of policyholders are subject to regulation under ERISA. If true, this could include ERISA's provisions relating to reporting, disclosure, and fiduciary responsibility. *See, e.g.*, 29 U.S.C. §§ 1021-1024, 1101-1108. If [the Eighth Circuit's] holding means that each policy is a plan, then some fiduciary could be responsible for carrying out ERISA's requirements as to each and every policy. Even if the [Eighth Circuit's] holding means that the conversion policies are deemed parts of the underlying plan from which they were converted, the fiduciaries of those plans might have to engage in reporting and disclosure activities that reflect not only the terms of the current plan, but of each and every permutation of "plan" terms as they exist in various conversion policies held by former employees. For example, summary plan descriptions describing current terms of many plans would likely be inaccurate as to persons holding various conversion policies acquired in past years. *See* 29 U.S.C. §1022.

As it is, employers and plans are none too zealous in meeting these reporting requirements. See Brustad, Orin D., *Perspective--Health Plans that Don't Comply with ERISA and the Code--What, Me Worry?* 10 *Benefits Law Journal* No.4 (Winter 1997), 1-5

The Department then went on to observe yet another serious problem with the Eighth Circuit's view that the benefit plan continues no matter that the employer would like to walk away:

> Moreover, attaching ERISA responsibilities to conversion policies would have serious consequences for employers who now enjoy the right to terminate welfare plans at will, absent contractual vesting or other special circumstances. *See, e.g., Barker v. Ceridian Corp.*, 122 F.3d 628, . . . (8th Cir. 1997). If ERISA responsibilities continue as to conversion policies even after a plan has been terminated, then such employers will find it more difficult to end their ERISA responsibilities by welfare plan termination. [footnotes omitted]

The Department of Labor objected to the regulatory burdens "given Congress' repeated admonitions that insurance regulation is to be left primarily to the states. *See, e.g.*, 29 U.S.C. §1144(b)(2) (ERISA preemption insurance 'savings' clause); 15 U.S.C. §§ 1011, *et seq.* (McCarran-Ferguson Act)." All these serious problems suggest reason for this Court to grant the writ.

CONCLUSION

For the foregoing reasons, the foregoing petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

APPEALS FROM THE UNITED STATES
DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI.
United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 96-3114
No. 96-3454

ANA PAINTER,
Plaintiff - Appellant,

v.

GOLDEN RULE INSURANCE COMPANY,
Defendant - Appellee.

Submitted: April 14, 1997
Filed: August 14, 1997

Before LOKEN, JOHN R. GIBSON, and MAGILL, Circuit Judges.

LOKEN, Circuit Judge.

Ana Painter claimed health insurance benefits under a conversion policy issued by Golden Rule Insurance Company ("Golden Rule"). Golden Rule denied coverage on the ground that Painter's cancer treatments were experimental and not medically necessary. The resulting dispute has now spawned two appeals without resolving the coverage question. In No. 96-3114, Painter appeals the district court's[1] dismissal of her state law claims for

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[1]The HONORABLE GEORGE F. GUNN, JR., United States District Judge for the Eastern District of Missouri.

malicious prosecution and breach of fiduciary duty as preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § § 1001 *et seq.* In No. 96-3454, Painter appeals the amount of attorney's fees awarded after Golden Rule's declaratory judgment action was dismissed because the parties had not exhausted their contractual remedies. We affirm both decisions.

I. Background.

In 1991, Golden Rule paid Painter's claims for ovarian cancer medical treatments under a group policy purchased by her employer, M.D. Care, Inc. The group policy was part of an employee welfare benefit plan governed by ERISA. After Painter's cancer went into remission, she requested that the group policy cover high dose chemotherapy and peripheral stem cell infusion treatments. Golden Rule denied that request. Painter's employment with M.D. Care terminated in August 1992; her continuation coverage under the group policy terminated in February 1993, when M.D. Care canceled the group policy. At that point, Painter exercised her "health insurance conversion privilege" under the group policy and purchased an individual "Conversion Policy" from Golden Rule.[2]

The First Lawsuit. Painter then proceeded with high dose chemotherapy cancer treatment and submitted a claim for those expenses under the Conversion Policy. Golden Rule denied coverage on the ground that this treatment was experimental and

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[2]The Consolidated Omnibus Budget Reconciliation Act of 1985 amended ERISA to require most sponsors of ERISA group health plans to provide "continuation coverage" upon termination of employment, *see* 29 U.S.C. §§ 1161-63, and to provide "the option of enrollment under a conversion health plan otherwise generally available [to employees] under the plan," § 1162(5). The parties assume that M.D. Care was required to provide Painter's continuation and conversion benefits. That assumption does not affect our resolution of the issues presented by these appeals. *See Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1343-45 (11th Cir. 1994).

not medically necessary. When Painter threatened to assert a variety of legal claims, Golden Rule commenced a declaratory judgment action in federal court, seeking a declaration that it is not obligated under the Conversion Policy to pay Painter's claims for these additional cancer treatments. After Painter moved to dismiss on a variety of grounds, Golden Rule conceded that the parties had not exhausted the Conversion Policy's procedure for determining medical necessity. The district court then dismissed the declaratory judgment action without prejudice, ordering Golden Rule to pay Painter's "reasonable attorney's fees and costs incurred in defending this action." Painter applied for an award of $102,619.75 in attorney's fees and now appeals the district court's award of $37,493.35 (our case No. 96-3454).

The Second Lawsuit. In December 1995, without exhausting the Conversion Policy's medical necessity procedures, Painter commenced an action in state court, seeking compensatory and punitive damages under state law on the theory that Golden Rule's actions in denying coverage and commencing the declaratory judgment action constituted malicious prosecution and breach of fiduciary duty. After Golden Rule removed the action, the district court granted Golden Rule's motion to dismiss, concluding that "a conversion policy obtained by an employee pursuant to an ERISA plan is within the scope of ERISA, and state law claims relating to the conversion policy are subject to ERISA's preemption provision." Painter appeals (our case No. 96-3114). We review an ERISA preemption ruling *de nova. See Arkansas Blue Cross & Blue Shield v. St. Marv's Hosp., Inc.*, 947 F.2d 1341, 1344 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992).

11. No. 96-3114 — The ERISA Preemption Issue.

Painter argues that ERISA does not preempt her state law claims because the Conversion Policy is an individual contract that does not implicate administration of M.D. Care's group

health plan. After M.D. Care terminated the group policy, Golden Rule had no relationship with M.D. Care or its ERISA plan. Therefore, Painter concludes, her state law claims do not "relate to" M.D. Care's plan within the meaning of ERISA's express preemption provision, 29 U.S.C. § 1144(a), and those claims should avoid ERISA preemption like the malicious prosecution claim in *Nill v. Essex Group, Inc.*, 844 F. Supp. 1313, 1318-20 (N.D. Ind. 1994).

The Supreme Court has decided sixteen ERISA preemption cases since the statute was enacted in 1974. *See California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832, 842-43 (1997) (Scalia, J., concurring). Most involved the proper scope of "relate to" preemption under § 1144(a), and the Court has struggled, particularly in its more recent decisions, with the inherent vagueness of that key statutory phrase. *Compare New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1676-80 (1995), *with Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). However, some ERISA cases involve the distinct question of conflict preemption — whether a state law is preempted because it conflicts with a specific portion of the complex ERISA statute. If there is a conflict, state law is preempted, *whether or not* "the statutory phrase 'relate to' provides further and additional support for the pre-emption claim." *Boggs v. Boggs*, 117 S. Ct. 1754, 1761 (1997). In our view, this is a case of conflict preemption.

To define the conflict between ERISA and Painter's state law claims, we must address an underlying legal issue — if Golden Rule denies Painter's claim for medical benefits after the Conversion Policy's contractual remedies have been exhausted, would a suit by Painter for wrongful denial of benefits be governed by ERISA's remedial provisions? In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43 (1987), the Supreme Court held that

ERISA remedies preempt "state common law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan." The Court explained:

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision.

Id. at 54. *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City*, 999 F.2d 298, 302-04 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994). Thus, if ERISA provides Painter remedies for the wrongful denial of Conversion Policy benefits, then her state law claims for tortious mishandling of her benefit claim are conflict-preempted.

We conclude that Painter's claim for benefits under the Conversion Policy is governed by ERISA. The issue turns on three statutory provisions. First, the ERISA provision governing claims for plan benefits, 29 U.S.C. § 1132(a)(1)(B), provides that an ERISA "participant" may sue "to recover benefits due to him under the terms of his plan." Second, the definition of "participant" in 29 U.S.C. § 1002(7) includes "any employee *or former employee* of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan." (Emphasis added.) In other words, a former employee such as Painter may be an ERISA participant entitled to sue for benefits under § 1132(a)(1)(B).

That leaves the question whether Painter's Conversion Policy benefits are "due [her] under the terms of [her] plan" within the meaning of § 1132(a)(1)(B). ERISA defines an "employee welfare benefit plan," such as M.D. Care's group health plan, to

mean "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants . . . through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). The group health policy M.D. Care purchased from Golden Rule either was itself an ERISA plan, or was part of a broader plan if M.D. Care's total plan or program included other components. A suit to recover benefits due Painter under that group policy, including continuation benefits due her as a former employee, would be governed by § 1132(a)(1)(B). Here, of course, the group policy has expired, and Painter is seeking medical benefits under Golden Rule's separate Conversion Policy. But the Conversion Policy came into being as a result of Painter exercising her right under the group policy to obtain this specific insurance policy. Thus, the right to a Conversion Policy was part of the plan or program "established" by M.D. Care to provide medical benefits for its current and former employees. As such, the Conversion Policy is a component of M.D. Care's ERISA plan. A suit to recover Conversion Policy benefits is governed by § 1132(a)(1)(B).

Because Painter's underlying claim for Conversion Policy benefits is governed by ERISA, her state law claims for Golden Rule's alleged mishandling of that claim are preempted under *Pilot Life*. This conclusion is consistent with the overwhelming majority of preemption decisions involving conversion policies and the ERISA plans which gave them birth. *See Peterson v. Amencan Life & Health Ins. Co.*, 48 F.3d 404, 407-08 (9th Cir.), *cert. denied*, 116 S. Ct. 377 (1995); *Glass v. United of Omaha Life*, 33 F.3d at 1346-47; *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812, 817 (9th Cir. 1992); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1157-58 (2d Cir. 1990); *Reynolds v. Massachusetts Cas. Ins. Co.*, 900 F. Supp. 915, 922 (E.D. Tenn. 1995), *rev'd on other grounds*, 113 F.3d 1450 (6th Cir. 1997); *Klosterman v. Western Gen. Mgmt., Inc.*, 805 F. Supp. 570, 573-

74 (N.D. III. 1992); *Beal v. Jefferson-Pilot Life Ins. Co.*, 798 F. Supp. 673, 677 (S.D. Ala. 1992); *Nechero v. Provident Life & Accident Ins. Co.*, 795 F. Supp. 374, 379-80 (D.N.M. 1992); *Mays v. Unum Life Ins. Co. of America*, 1995 WL 317102, 3 (N.D. Ill. 1995); *but see Mimbs v. Commercial Life Ins. Co.*, 818 F. Supp. 1556, 1562-63 (S.D. Ga. 1993). The district court correctly concluded that ERISA preempts Painter's state law claims.

III. No . 96-3454 — The Attorney Fee Issue.

When Golden Rule filed its declaratory judgment action, Painter moved to dismiss on many grounds, including (i) ERISA does not govern claims under the Conversion Policy, (ii) in any event, ERISA does not afford Golden Rule standing to seek a declaratory judgment construing the Conversion Policy,[3] and (iii) failure to exhaust the Policy' s procedure for an independent determination of what is medically necessary. Golden Rule promptly admitted lack of exhaustion and moved to stay or voluntarily dismiss its declaratory judgment action for this purpose. Painter instead urged the court to dismiss for lack of subject matter jurisdiction.

After moving the case toward trial for one year, the district court referred the pending stay and dismissal motions to a magistrate judge, who recommended that the court (i) voluntarily dismiss the action under Fed. R. Civ. P. 41(a)(2) for failure to exhaust contract remedies, and (ii) order Golden Rule to pay Painter's reasonable costs and attorney fees because it had filed a premature declaratory judgment action. The district court adopted that recommendation, granted Golden Rule's voluntary dismissal motion, dismissed the case without prejudice, and ordered Golden Rule to pay Painter's "reasonable attorney's fees and costs

[3]Though this issue is not before us, we refer the interested reader to the thorough discussion and contrary conclusion in *Connecticut Gen. Life Ins. Co. v. Cole*, 821 F. Supp. 193, 196-98 (S.D.N.Y. 1993).

incurred in defending this action." However, while the court's Order dismissed the action pursuant to Rule 41(a)(2), its accompanying Memorandum declared that it "lacks subject matter jurisdiction over this case, as applicable [contract] remedies have not been exhausted."

Counsel for Painter then applied for an award of $102,619.75 in attorney fees. Golden Rule argued that the court had no power to award attorney fees after dismissing for lack of subject matter jurisdiction. Recognizing its prior error, the court ruled that failure to exhaust contract remedies is not a jurisdictional defect depriving the court of power to condition voluntary dismissal on the payment of Painter' s reasonable attorney fees. After soliciting further billing information from Painter's attorneys, the court concluded that much of the fee request was excessive under Rule 41(a)(2) standards. *See generally Kern v. TXO Prod. Corp.*, 738 F.2d 968, 972-73 (8th Cir. 1984). The court awarded Painter fees of $37,493.35. She appeals that award.

Painter's argument on appeal is virtually incoherent. Apparently, she argues that the district court's initial voluntary dismissal order was a final order making Painter a prevailing party under ERISA, that the order stated she would be paid all her attorney fees, that she therefore gave up her right to appeal the order, and that the district court's subsequent order reducing her fees was contrary to this law of the case. The argument has many fatal flaws. First, it is not clear from the record on appeal that the district court's initial voluntary dismissal order was a final order, and Painter made no effort to clarify that issue, then or now. Second, Painter was not a prevailing party under ERISA. As Part II of this opinion makes clear, the district court properly denied her motion to dismiss for lack of ERISA subject matter jurisdiction. We also reject Painter's suggestion that dismissal of Golden Rule's declaratory judgment action was inevitable. The district court never considered Golden Rule's alternative motion to stay the action while contract remedies were exhausted; had Golden

Rule pressed that point after the court corrected its subject matter jurisdiction ruling, a stay might have been granted. Finally, the district court's initial order expressly stated that it was dismissing under Rule 41(a)(2); if Painter's attorneys construed that order as authorizing a fee award on some other basis, they have only themselves to blame.

For these reasons, we find no error of law in the district court's analysis of the Rule 41 (a)(2) attorney fee issue. After careful review of the record, we conclude that the court did not abuse its considerable discretion in reducing Painter's initial fee request.

IV. Conclusion.

Painter concludes her brief in No. 96-3114 by suggesting that if her state law claims are preempted by ERISA, the district court erred in not granting her leave to amend her complaint to assert new claims under ERISA. Painter never made this request to the district court, either before or after that court ruled on the preemption issue. Even now, she does not advise this court what ERISA claims she wishes to assert. In the first lawsuit, Painter fought Golden Rule's declaratory judgment action in the district court for nearly three years without asserting ERISA claims of her own.[4] We ordinarily do not consider issues raised for the first time on appeal. *See Miller v. Federal Emergency Mgmt. Agency*,

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[4]Painter's challenge to Golden Rule's declaratory judgment action is one of many roadblocks her attorneys have erected to avoid prompt resolution of the Conversion Policy coverage issue that is the core of this dispute. We think it deplorable that the coverage issue is not yet ripe for decision. But because this is the result of Painter's litigation strategy, we will refrain from attacking the resulting impasse *sua sponte*.

57 F.3d 687, 689 (8th Cir. 1995). Painter has given us no good reason to depart from this practice here.

The judgments of the district court are affirmed.

A true copy.

Attest:

CLERK, U. S. COURT OF APPEALS, EIGHTH CIRCUIT.

APPENDIX B

UNITED STATES COURT 0F APPEALS
FOR THE EIGHTH CIRCUIT
No 96-3114/3454EMSL

Order Denying Petition for
Rehearing and Suggestion
for Rehearing En Banc

Ana Painter,
Appellant,

v.

Golden Rule Insurance Company,
Appellee.

The suggestion for rehearing en banc is denied. The petition for rehearing by the panel is also denied. The Secretary of Labor's amicus brief is rejected for untimely filing.

November 17, 1997

Order Entered at the Direction of the Court
BY:/s/ MICHEAL E. GAINS
Clerk, U.S. Count of Appeals, Eighth Circuit

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:96CV00249 GFG

ANA PAINTER,
Plaintiff(s),

vs.

GOLDEN RULE INSURANCE COMPANY,
Defendant(s).

MEMORANDUM AND ORDER

This matter is before the Court on defendant's motion to dismiss, for a more definite statement or to strike. Ana Painter, a Missouri resident, filed a two-count action in Missouri state court against Golden Rule Insurance Co., an Illinois corporation, for malicious prosecution and breach of fiduciary duty. Painter alleged that the wrongful filing and prosecution by Golden Rule of an action in this Court seeking a declaration that it was not liable for certain medical expenses incurred by Painter caused her damages in the form of attorney's fees in defending the action, and emotional distress. Painter sought compensatory damages of $25,000 and punitive damages "in excess of $25,000" in each count.

Golden Rule removed the action to this Court based on federal question jurisdiction on the ground that the claims relate to an employee benefit plan under the Employee Income Security Act (ERISA), 29 U.S.C. § 1002(1). Golden Rule asserted that the action was also removable based on diversity jurisdiction.

The record establishes the following. As an employee of M.D. Care, Inc., Painter was covered by a group accident and sickness insurance policy issued by Golden Rule. In December 1991 Painter submitted claims under this policy for the treatment of ovarian cancer; Golden Rule paid these claims. In June and October 1992, while in remission, Painter sought pre-certification of coverage for high dose chemotherapy and peripheral stem infusion (psi). Golden Rule denied the precertification request.

When the M.D. Care, Inc., policy terminated on February 1, 1993, Painter exercised her contractual right of conversion and purchased from Golden Rule an individual policy. In March 1993 Painter incurred medical expenses and submitted claims under the conversion policy for the high dose chemotherapy and psi treatment of ovarian cancer.

On September 1, 1993, Golden Rule filed a declaratory judgment action in this Court,[1] cause no. 4:93CV2069, against Painter seeking a declaration that it was not liable for these expenses under the original policy because it was not in force when the expenses were incurred, or under the conversion policy because the terms of that policy ("medically necessary") excluded such expenses. Golden Rule asserted that the action arose under ERISA. Thereafter Golden Rule filed a first amended complaint which eliminated reference to ERISA. On November 5, 1993, Painter moved to dismiss the amended complaint on the ground that Golden Rule failed to plead any basis for subject matter jurisdiction. She argued that the Declaratory Judgment Act did not provide an independent ground for jurisdiction and Golden Rule had no standing to bring an action under ERISA. She argued in the alternative that the action should be dismissed because Golden Rule did not exhaust internal plan administrative procedures (to determine the question of medical necessity), as required by ERISA.

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[1]The Honorable Charles A. Shaw.

On December 13, 1993, Golden Rule filed a motion for a temporary stay of proceedings or voluntary dismissal in light of the failure to exhaust the administrative procedure noted by Painter. By order dated January 31, 1995, the Court granted Golden Rule's request for voluntary dismissal, conditioning dismissal upon Golden Rule paying Painter's reasonable attorney's fees and costs.[2] The issue of attorney's fees was pending when Painter filed the present action on December 27, 1995, and is still pending.

In the motion now before the Court, Golden Rule argues that the state law claims should be dismissed as preempted by ERISA. Alternatively, Golden Rule argues that to the extent the allegations in the complaint may be construed to state an ERISA claim, Painter should be required to provide a more definite statement of such claim and eliminate remedies, such as damages for emotional distress and punitive damages, not available under ERISA. Riser responds that the prior suit filed by Golden Rule was not an ERISA action and that the present action is not preempted by ERISA because it does not require interpretation of any plan document as to whether Painter is or is not entitled to a benefit.

ERISA'S preemption provision, 29 U.S.C. § 1144(a), provides in relevant part that "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." A state law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 8 (1987). ERISA's preemption language is "con-

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[2]The Court stated that it lacked subject matter jurisdiction because of the failure to exhaust administrative remedies. In a subsequent order dated August 24, 1995, on the question of the Court's authority to impose attorney's fees against Golden Rule, the Court noted that it had erred in stating it lacked subject matter jurisdiction

spicuous in its breadth." *Robinson v. Linomaz*, 58 F.3d 365, 370 (8th Cir. 1995) (quoted case omitted).

A conversion policy obtained by an employee pursuant to an ERISA plan is within the scope of ERISA, and state law claims relating to the conversion policy are subject to ERISA's preemption provision. *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812, 817 (9th Cir. 1992). The Court concludes that the two state law claims asserted by Painter relate to the original policy and the conversion policy and are thus preempted. Under Missouri law, recovery for malicious prosecution requires proof that the defendant lacked probable cause for commencing an action against the plaintiff; probable cause for initiation of an action includes a reasonable belief that the claim may be valid under applicable law. *Neal v. Sparks*, 773 S.W.2d 481, 488 (Mo. Ct. App. 1989). Here such a determination would necessarily require an analysis of the insurance policy terms.

The breach of fiduciary duty claim is similarly related to the policies. *See, e.g., Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993). The fact that ERISA may not provide a cause of action because the defendant is not a fiduciary under the terms of the statute does not limit the scope of ERISA preemption. *Robinson v. Linomaz*, 58 F.3d at 370.

Accordingly,

IT IS HEREBY ORDERED that defendant's motion to dismiss the complaint is granted.

IT IS FURTHER ORDERED that any pending motions are denied as moot.

Dated this 8th day of July, 1996.

By:/s/ George F. Gunn, Jr.
GEORGE F. GUNN, JR
UNITED STATES DISTRICT JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 4:96CV00249 GFG

ANA PAINTER,
Plaintiff(s),

vs.

GOLDEN RULE INSURANCE COMPANY,
Defendant(s).

JUDGMENT

Pursuant to the Memorandum and Order filed herein this day,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that plaintiff's complaint is dismissed.

Dated this 8th day of July, 1996..

By:/s/ George F. Gunn, Jr.
GEORGE F. GUNN, JR
UNITED STATES DISTRICT JUDGE